

COUNTY OF LOS ANGELES

# SHERIFF'S DEPARTMENT

*A Tradition of Service*

DATE: February 8, 2007

OFFICE CORRESPONDENCE

FILE NO.

FROM: JOHNNY G. JURADO, COMMANDER  
LEADERSHIP AND TRAINING DIVISION

TO: CARL H. DEELEY, CAPTAIN  
LANCASTER STATION

SUBJECT: EXECUTIVE FORCE REVIEW COMMITTEE FINDINGS AND RECOMMENDATIONS  
USE OF FORCE, OCTOBER 7, 2006, FO2182537

The purpose of this memo is to notify you of the review committee's findings and recommendations concerning the use of force incident which occurred on October 7, 2006.

The Committee met on February 8, 2007 and consisted of me and Commanders Eric B. Smith (Leadership and Training Division), and Cecil W. Rhambo (FOR I). The Committee determined the use of force by [REDACTED] and Deputies [REDACTED] Shannon Knight, [REDACTED] and [REDACTED] was within Department policy.

Please advise the [REDACTED] and deputies of this finding.

JGJ:MOT:mt

Incident Information								
URN:	406-22309-1135-145			Date:	Saturday, October 7, 2006		Time:	2250 Hrs.
Location:	Sierra View Ave., Lancaster							
City or Station:	Lancaster							
Bureau/Station/Facility:	FOR I/Lancaster Station				Admin. Investigation: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Employee Witnesses								
Emp. #	Last Name		First Name		Middle Name			
Emp. #	Last Name		First Name		Middle Name			
Emp. #	Last Name		First Name		Middle Name			
Non-Employee Witnesses								
Last Name		First Name		Middle Name		Age	D.O.B.	
None								
Street Address			City	Zip Code	Work Ph.	Home Ph.		
Last Name		First Name		Middle Name		Age	D.O.B.	
Street Address			City	Zip Code	Work Ph.	Home Ph.		
Last Name		First Name		Middle Name		Age	D.O.B.	
Street Address			City	Zip Code	Work Ph.	Home Ph.		
On Duty Supervisor								
Emp. #	Last Name	First Name	Middle Name	Rank	Present	Witness to Incident		
				Sgt.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Emp. #	Last Name	First Name	Middle Name	Rank	Present	Witness to Incident		
					YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
Watch Sergeant								
Emp. #	Last Name		First Name		Middle Name			
	Bullard		Steven		R.			
Watch Commander								
Emp. #	Last Name		First Name		Middle Name			
	Hindman		William		M.			

Watch Commander's Signature: \_\_\_\_\_ Emp #: \_\_\_\_\_

Copy Provided to Employee by: \_\_\_\_\_ Emp #: \_\_\_\_\_

Supervisor Completing Form: \_\_\_\_\_ Sgt. Clay Anderson  
(Print) Emp #: \_\_\_\_\_

Unit Commanders Signature: \_\_\_\_\_ Emp #: \_\_\_\_\_ Date Signed: \_\_\_\_\_

PSTD Use Only
FO#

Original: Unit Commander  
Copy: P.S.T.D. Headquarters,  
Employee

## URN:

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(AW) Arwen	(FH) Firearm (Handgun)	(PO) Personal Weapon (Other)
(BC) Baton: (Control)	(FR) Firearm (Rifle)	(RS) Resistance
(BI) Baton: (Impact)	(FS) Firearm (Shotgun)	(CN) Restraint Device (Capture Net)
(BF) Bodily Fluids	(FO) Firearm (Other)	(RH) Restraint Device (Handcuffs)
(CN) Canine	(FB) Flashbang	(HB) Restraint Device: Hobble (Legs Only)
(CR) Carotid Restraint	(FL) Flashlight	(TP) Restraint Device: Hobble (TARP)
(CH) Choke Hold	(OE) Other Weapon: Edged	(RE) Restraint Device: REACT Belt
(CT) Control Holds: (Control Techniques)	(OV) Other Weapon: Vehicle	(SP) Sap
(TT) Control Holds: (Team Takedown)	(OB) Other Weapon: Blunt Object	(SH) Shield
(TD) Control Holds: (Takedown)	(OO) Other Weapon: Other	(SG) 37mm Stinger
(CE) Chemical	(PK) Personal Weapon: Feet/Leg: (Kick)	(SB) Sting Ball
(OC) Chemical Agents (OC Spray)	(PS) Personal Weapon: Feet/Leg: (Sweep)	(ST) Stun Bag
(TG) Chemical Agents (Tear Gas)	(PH) Personal Weapon (Hand/Arm)	(TR) Taser
(EX) Explosives	(PP) Personal Weapon (Push)	(UC) Uncooperative

(AB) Abrasion	(DB) Dog Bite	(PA) Paralysis
(BR) Bruise	(FR) Fractures	(PW) Puncture Wound
(BU) Burn	(GS) Gunshot	(SD) Soft Tissue Damage
(CP) Complaint of Pain	(HB) Human Bite	(ST) Sprain/Twists
(CO) Concussion	(LC) Lacerations	(UN) Unconscious
(DH) Death	(ND) Nerve Damage	(RM) Refused Med Treatment
(DI) Dislocation	(OD) Organ Damage	(NN) NONE

(AD) Abdomen	(FA) Face	(HI) Hip
(AK) Ankle	(FE) Feet	(IN) Internal
(AR) Arm	(FI) Fingers	(KN) Knees
(BK) Back	(GE) Genitals	(LE) Leg
(BT) Buttocks	(GR) Groin	(NK) Neck
(CH) Chest	(HD) Hands	(NO) Nose
(EL) Elbow	(HE) Head	(SH) Shoulder
		(WR) Wrist

**(Only One Code Per Block)**

[illegible]

# Supervisor's Report on Use of Force INVOLVED EMPLOYEE INFORMATION

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## Involved Employee

<b>E1</b>	Employee #	Last Name	First Name	Middle Name
	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Race: W	Unit of Assignment: Lancaster Station	Work Assignment (Unit #, Module, etc.): 111A
	Shift: <input type="checkbox"/> EM <input type="checkbox"/> Day <input checked="" type="checkbox"/> PM	<input checked="" type="checkbox"/> Regular Shift <input type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: 6' 03" Weight: 215 lbs.
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input checked="" type="checkbox"/> Significant Force <input type="checkbox"/>
<b>E2</b>	Employee #	Last Name	First Name	Middle Name
		Knight	Shannon	
	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Race: W	Unit of Assignment: Lancaster Station	Work Assignment (Unit #, Module, etc.): 113
	Shift: <input checked="" type="checkbox"/> EM <input type="checkbox"/> Day <input type="checkbox"/> PM	<input checked="" type="checkbox"/> Regular Shift <input type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: 5' 07" Weight: 180 lbs.
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input checked="" type="checkbox"/> Significant Force <input type="checkbox"/>
<b>E3</b>	Employee #	Last Name	First Name	Middle Name
	Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Race: W	Unit of Assignment: Lancaster Station	Work Assignment (Unit #, Module, etc.): 114
	Shift: <input checked="" type="checkbox"/> EM <input type="checkbox"/> Day <input type="checkbox"/> PM	<input type="checkbox"/> Regular Shift <input checked="" type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: 5' 05" Weight: 120 lbs.
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input checked="" type="checkbox"/> Significant Force <input type="checkbox"/>
<b>E4</b>	Employee #	Last Name	First Name	Middle Name
	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Race: A	Unit of Assignment: Compton Station	Work Assignment (Unit #, Module, etc.):
	Shift: <input type="checkbox"/> EM <input type="checkbox"/> Day <input checked="" type="checkbox"/> PM	<input checked="" type="checkbox"/> Regular Shift <input type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: 5' 08" Weight: 180 lbs.
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input checked="" type="checkbox"/> Significant Force <input type="checkbox"/>
<b>E</b>	Employee #	Last Name	First Name	Middle Name
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Unit of Assignment:	Work Assignment (Unit #, Module, etc.):
	Shift: <input type="checkbox"/> EM <input type="checkbox"/> Day <input type="checkbox"/> PM	<input type="checkbox"/> Regular Shift <input type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: Weight:
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input type="checkbox"/> Significant Force <input type="checkbox"/>
<b>E</b>	Employee #	Last Name	First Name	Middle Name
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Unit of Assignment:	Work Assignment (Unit #, Module, etc.):
	Shift: <input type="checkbox"/> EM <input type="checkbox"/> Day <input type="checkbox"/> PM	<input type="checkbox"/> Regular Shift <input type="checkbox"/> OT Shift <input type="checkbox"/> Off Duty	Age:	Height: Weight:
	Medical Exam/Treatment <input type="checkbox"/>	If Admitted, Name of Hospital:	Coroner Case #	Directed Force <input type="checkbox"/> Significant Force <input type="checkbox"/>

# Supervisor's Report on Use of Force

## SUSPECT INFORMATION

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### Suspect Information

S	Last Name Arellano	First Name Joseph	Middle Name
	AKA Last Name	First Name	Middle Name
	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Race: H	Street Address: [REDACTED]
		City: [REDACTED]	State & Zip Code: [REDACTED]
	Work Phone: [REDACTED]	Home Phone: [REDACTED]	Age: 22
		Height: 5' 07"	D.O.B. 06/29/84
		Weight: 230 lbs.	Armed? <input type="checkbox"/>
	Booking #: 9235808	Primary Charge: 148(A) PC	Secondary Charge:
		Criminal History	
	Hospital Admission? <input type="checkbox"/>	Rec'd Treatment At: Lancaster Community Hospital	Coroner Case#: Mental History <input type="checkbox"/>
	Under Influence: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Substance: Alcohol	Photos of Suspect's Injuries <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

### Suspect Interview

Date: 10/08/06	Time: 1145 hrs.	Audiotape: <input checked="" type="checkbox"/>	Videotape: <input checked="" type="checkbox"/>
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### Suspect Information

S	Last Name	First Name	Middle Name
	AKA Last Name	First Name	Middle Name
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Street Address:
		City:	State & Zip Code:
	Work Phone:	Home Phone:	Age:
		Height:	D.O.B.
		Weight:	Armed? <input type="checkbox"/>
	Booking #:	Primary Charge:	Secondary Charge:
		Criminal History	<input type="checkbox"/>
	Hospital Admission? <input type="checkbox"/>	Rec'd Treatment At:	Coroner Case#: Mental History <input type="checkbox"/>
	Under Influence: <input type="checkbox"/> YES <input type="checkbox"/> NO	Substance:	Photos of Suspect's Injuries <input type="checkbox"/> YES <input type="checkbox"/> NO

### Suspect Interview

Date:	Time:	Audiotape: <input type="checkbox"/>	Videotape: <input type="checkbox"/>
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### Suspect Information

S	Last Name	First Name	Middle Name
	AKA Last Name	First Name	Middle Name
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Street Address:
		City:	State & Zip Code:
	Work Phone:	Home Phone:	Age:
		Height:	D.O.B.
		Weight:	Armed? <input type="checkbox"/>
	Booking #:	Primary Charge:	Secondary Charge:
		Criminal History	<input type="checkbox"/>
	Hospital Admission? <input type="checkbox"/>	Rec'd Treatment At:	Coroner Case#: Mental History <input type="checkbox"/>
	Under Influence: <input type="checkbox"/> YES <input type="checkbox"/> NO	Substance:	Photos of Suspect's Injuries <input type="checkbox"/> YES <input type="checkbox"/> NO

### Suspect Interview

Date:	Time:	Audiotape: <input type="checkbox"/>	Videotape: <input type="checkbox"/>
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